



**ELIGIBILITY APPLICATION
FOR THE
TAXI, RIDELINE SPECIALIZED TRANSPORTATION PROGRAMS**

The Taxi Program

For Waukesha County residents, who are non/limited drivers, age 65 years or older, and able to enter or exit an automobile with little or no assistance.

AND Waukesha County residents, who are non-drivers under the age of 65, able to enter or exit an automobile with little or no assistance and receive either SSI or SSDI. A Benefits Verification Form can be obtained from:

Social Security Office
707 North Grand Avenue
Waukesha, WI 53186
Phone: 1-800-772-1213

The RideLine Program

For Waukesha County residents, who are non/limited drivers, age 65 or older, unable to enter or exit an automobile, and require an accessible vehicle, or have no taxi service in their community, or need to travel outside of the taxi service area.

AND for those Waukesha County residents who are non-drivers under the age of 65, unable to enter or exit an automobile, use either a wheelchair, scooter, cane, walker, crutches, or are legally blind.

Service to adjoining County ONLY for second opinions, consultations, or services NOT duplicated in Waukesha County.

Send your: 1) Completed Application
 2) RideLine Fare Determination Form (Choose Option A or B)

To: Waukesha County Department of Senior Services
 1320 Pewaukee Road, #130
 Waukesha, WI 53188

Or Fax your completed paperwork to (262) 896-8273

**RideLine & Local Shared-Fare Taxi
APPLICATION FORM**

Information provided on this application will be kept confidential and used by Waukesha County Department of Senior Services for determining eligibility for the specialized transportation programs. **If you need assistance filling out this form, call the Department of Senior Services at (262) 548-7848.** **(PLEASE PRINT)**

Name _____ Date of Birth _____ Age _____

Mailing Address _____

Street Address (if different) _____

City/Village/Town _____ Zip _____

Daytime Phone: (____) _____ Evening Phone: (____) _____

Other family members living at the above residence: *[Please provide name, age and relationship to applicant]* _____

Shared-Fare Taxi applicants,
64 years of age or younger:
Remember to submit a
Benefits Verification Form with
your application!

Social Security Number _____ / _____ / _____
Medicare Number _____ / _____ / _____
Medicaid (Title 19) Number _____ / _____ / _____

1. Do you own a vehicle? ☐ Y ☐ N Do you drive? ☐ Y ☐ N ☐ Sometimes

2. Do you have any driving restrictions or limitations? ☐ Y ☐ N

If yes, please explain _____

3. Are you able to enter and exit a vehicle with little or no assistance? ☐ Y ☐ N

4. Is your disability or limitation temporary? ☐ Y ☐ N

If yes, how long do you expect it to last? _____

5. Is your disability or limitation due to ☐ **an accident** or ☐ **a work-related injury**?

6. Do you use any of the following aides? ☐ Y ☐ N *If Yes, check all that apply.*

- ☐ cane
- ☐ white cane
- ☐ orthotic/prosthetic device
- ☐ guide animal
- ☐ crutches
- ☐ walker
- ☐ portable oxygen

- ☐ manual wheelchair
If oversized:
length _____
width _____
- ☐ powered wheelchair
If oversized:
length _____
width _____

- ☐ scooter
If oversized:
length _____
width _____
- ☐ Other: _____

7. For **RideLine** applicants, an “attendant” is defined as “*a mobility aide to the passenger, necessary to facilitate the safe transportation of the passenger.*” In a very real sense, **if an attendant is deemed necessary** to provide mobility assistance or supervision to ensure safety beyond the basic door-to-door service provided by the RideLine program, **all travels will require an attendant and no rides can be arranged without one.**

Do you require an attendant when you travel? ☐ Y ☐ N

Be sure to have the **Medical Verification Form** completed, signed, and submitted with your application.

8. If someone other than the applicant will be arranging trips, provide his/her name and phone number: Name _____ Phone (____) _____

Emergency Contact Information

Provide information on *at least two* persons to be contacted in case of emergency

1. Name _____ Phone (____) _____ Relationship _____

2. Name _____ Phone (____) _____ Relationship _____

I believe the information provided is true and correct. I understand that deliberately providing false information is punishable by law and may jeopardize the receipt of services. I hereby authorize Waukesha County Department of Senior Services to verify the information in this application.

Signature of Applicant _____ **Date** _____

Application being completed by a person other than the applicant, please complete the following:

Name _____ Relationship to Applicant _____

Agency Affiliation (if appropriate) _____

Address _____

City/Village/Town _____ Zip _____

Daytime Phone (____) _____ Evening Phone (____) _____

Signature _____ **Date** _____

**RideLine & Local Shared-Fare Taxi
Medical Verification Form**

Information provided on this form and from all Professional Healthcare Providers will be kept confidential and used by Waukesha County Department of Senior Services for determining eligibility for specialized transportation programs.

If you need assistance filling out this form, call the Department of Senior Services at (262) 548-7848.

(PLEASE PRINT)

The medical information supplied on this form is for:

Name _____ Date of Birth _____ Age _____

Mailing Address _____

Street Address (*if different*) _____

City/Village/Town _____ Zip _____

Daytime Phone: (____) _____ Evening Phone: (____) _____

* * * * *

What disabilities or limitations prevent you from independent mobility?

Check all that apply:

☐ **Non-ambulatory:**

requires permanent use of a wheelchair

☐ **Restricted Mobility:**

condition causes difficulty walking; requires the use of a mobility aid

☐ **Arthritis:**

causes a functional motor defect in any two major limbs

☐ **Cardiac Disease:**

resulting in marked limitation of physical activity

☐ **Respiratory Impairment:**

occurs when climbing steps or walking

☐ **Amputation of**

LEG: ☐ *right* ☐ *left*

ARM: ☐ *right* ☐ *left*

☐ **Pacemaker:**

condition interferes with independent mobility

☐ **Dialysis:**

requires use of kidney dialysis machine and causes post-treatment weakness

☐ **Chemotherapy or Radiation:**

causes post-treatment weakness

☐ **Spinal Disorders:**

causes motor and sensory loss, osteoporosis with pain, limit of movement

☐ **Nerve Root Compression**

Syndrome:

causes pain and motion limitation in back or neck

☐ **Visual Impairment:**

interferes with independent mobility, legally blind

☐ **Hearing Impairment:**

interferes with independent mobility

☐ **Diabetes:**

condition status interferes with independent mobility

☐ **Autism:**

interferes with independent mobility

☐ **Developmental Disabilities:**

interferes with independent mobility

☐ **Aging:**

limitations to mobility due to advanced age with fatigue and decreased energy level; restricted mobility and slowed response time; and/or chronic or acute mental impairments

☐ **Mental or Emotional Impairment:**

preventing independent mobility

☐ **Neurological Impairment:**

☐ Cerebral Palsy

☐ Muscular Dystrophy

☐ Parkinson's Disease

☐ Epilepsy

☐ Seizure Disorder

☐ Other: _____

☐ Multiple Sclerosis

☐ Traumatic Brain Injury

Comments:

* * * * *

Authorization to Release Information:

The Professional Healthcare Provider and Clinic listed below is familiar with my disability or medical condition, and is authorized by me to provide information to Waukesha County Department of Senior Services staff in order to complete the eligibility process or verify my application for subsidized specialized transportation services:

The Healthcare Professional named is a:

☐ Physician

☐ Nurse

☐ Therapist

☐ Social Worker

☐ Home Health Aid

☐ Other: _____

Applicant's Signature: _____ **Date:** _____

Healthcare Professional Name: _____

Medical Office/Clinic: _____

Medical Office/Clinic Address: _____

Medical Office/Clinic Phone: (____) _____ FAX: (____) _____

**Waukesha County Department of Senior Services
RIDELINE FARE DETERMINATION FORM**

Name _____ Birth Date _____

Address _____ Apt # _____ Zip _____

City _____ Phone (____) _____

What is your Title 19 number? _____

If you receive Title 19 or COP (Community Option Program), do not complete the remainder of this page.

Choose OPTION A or OPTION B IF you do not receive Title 19 or COP

OPTION A: I do not wish to divulge my financial information. I agree to pay the following fare:

One-way trip within the same community:	\$7.25
One-way trip from one community to another	\$9.75
One-way trip to an adjoining County (available ONLY for medical and ONLY if service is NOT available in Waukesha County):	\$16.75

Signature _____ Date _____

OPTION B: I have listed my financial information for the Department of Senior Services. The information will be used to determine my RideLine fares based upon my ability to pay and the 2003 fare structure.

	<i>Passenger</i>	<i>Spouse</i>
1) Average Monthly Income:	\$ _____	\$ _____
2) Total Liquid Assets:	\$ _____	\$ _____
3) Average Monthly Medical Expenses:	\$ _____	\$ _____

- 1) **Average Monthly Income:** include your social security, pension, disability, wages, interest/dividends, rental income, and any other income you may receive.
- 2) **Total Liquid Assets:** include savings and checking accounts, investments (CD, stock, bonds).
- 3) **Average Monthly Medical Expenses:** include medicine, medical supplies, health insurance premiums, and dental, doctor or hospital bills. DO NOT INCLUDE medical expenses paid for by Medicare, Medicaid, or other insurance.

This information is true and complete to the best of my knowledge. I authorize the use of this information by representatives of the Waukesha County Department of Senior Services for the purposes of verification. I understand this information will remain confidential.

Signature _____ Date _____

Please return this completed form to: Waukesha County Department of Senior Services
130 Pewaukee Road, Suite 130
Waukesha, WI 53188

OR FAX TO (262) 896-8273